Patient Centered Medical Home (PCMH) Update

Sep 2012

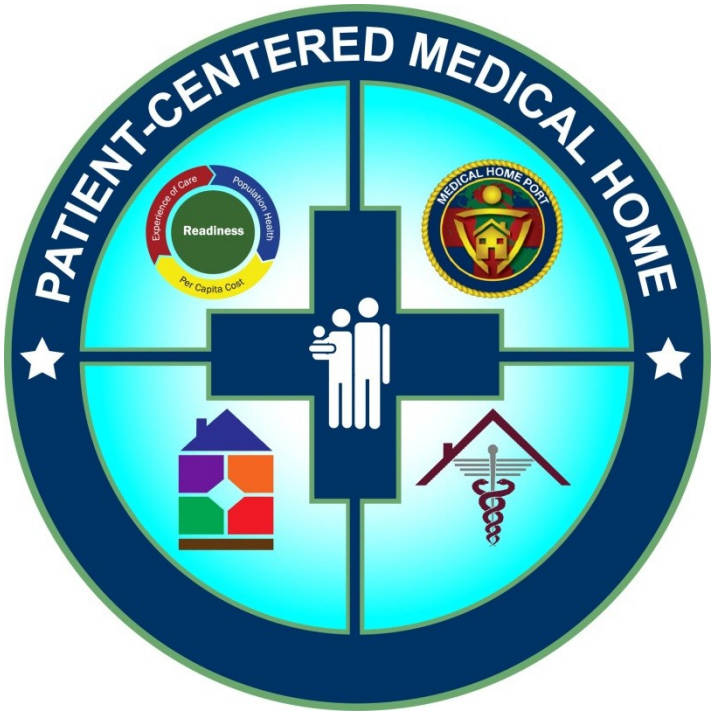
PCMH Primary Care Division

Office of the Chief Medical Officer

TRICARE Management Activity

Overview

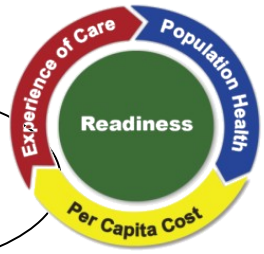
- Why PCMH? Strategy Review
- Governance and Stakeholders
- Performance Measures
- Enrollment
- NCQA Recognition
- Nurse Advice Line
- Problem Areas
- Way Ahead



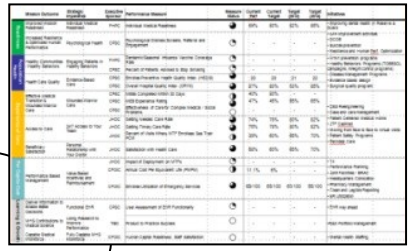
Supporting the MHS Strategy

2009

Quadruple Aim

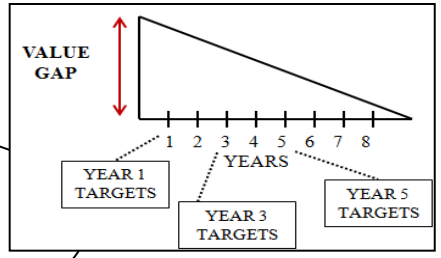


Strategic Imperatives



2010

Performance Gap



2011

Portfolio of Strategic Initiatives

Strategic Initiative Portfolio
- PCMH
- Performance Planning
- Psychological Health
- IMR Programs
- National Prevention Strategy
- …

Strategy Review

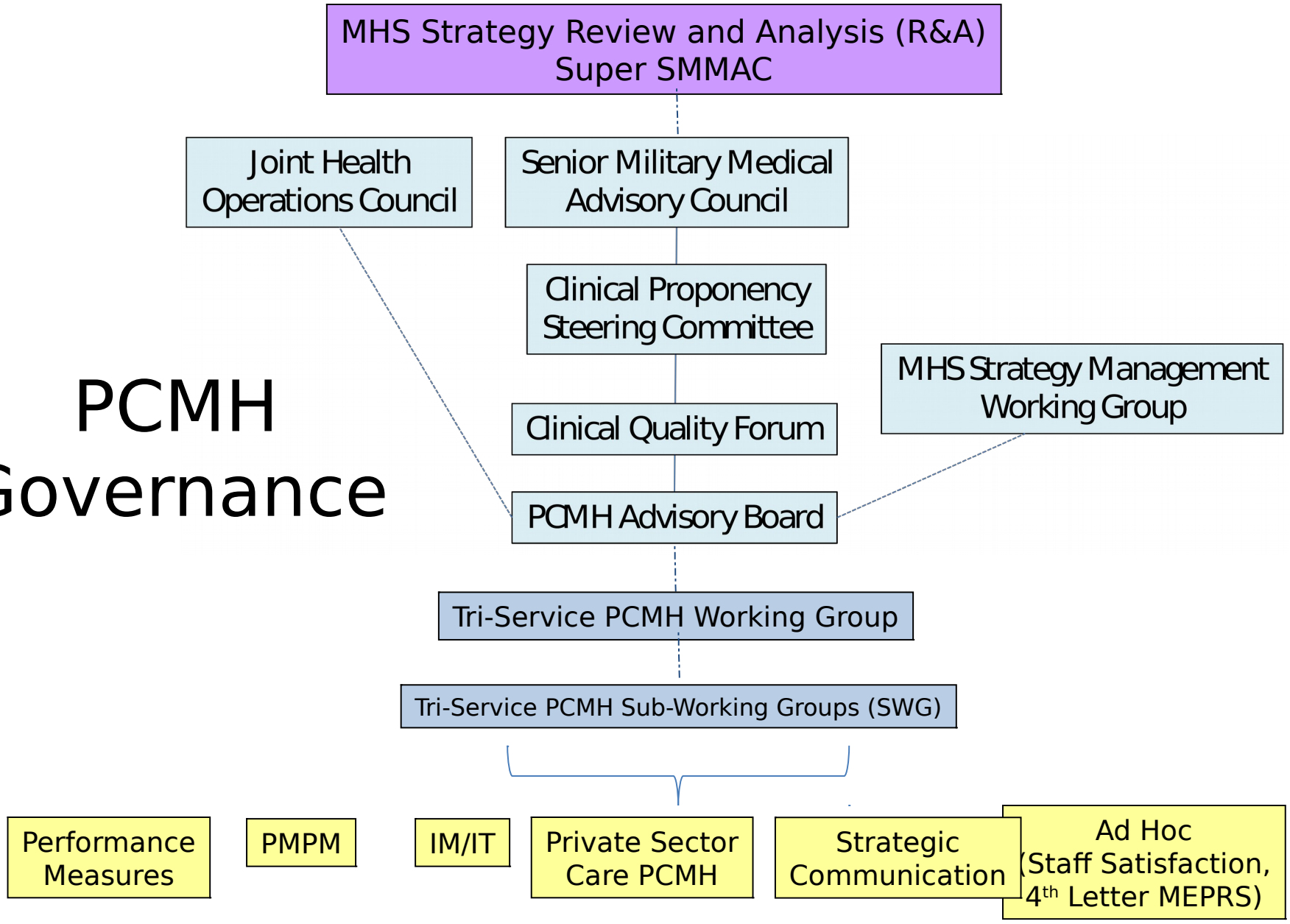
- Major drivers
  - Rising Costs – more beneficiaries, more entitlements and higher utilization
  - Persistently low satisfaction relative to private sector care
    - Access to care, access to same provider, lack of specialty care coordination and parking
- Foundational step to Accountable Care Organization
- Goal – Implement PCMH model of care at all 470+ primary care practices
  - Near term – improve PCM continuity, access to care and patient satisfaction
  - Mid term – manage demand, reduce primary care leakage and ED/primary care/specialty care utilization, reduce private sector care costs, improve HEDIS measures and medically readiness
  - Longer-term impacts – Improve beneficiary health status, increase MTF capacity and enrollment and improve MTF resource optimization

MHS Strategic Alignment

"The Department of Defense (DOD) has identified 11 initiatives aimed at slowing its rising health care costs, but has not fully applied results-oriented management practices in developing plans to implement and monitor its initiatives. Results-oriented management practices include developing plans that identify goals, activities, and performance measures; resources and investments … At the conclusion of GAO's review, DOD had completed and approved a detailed implementation plan, including a cost savings estimate, for just 1 of its 11 initiatives. "

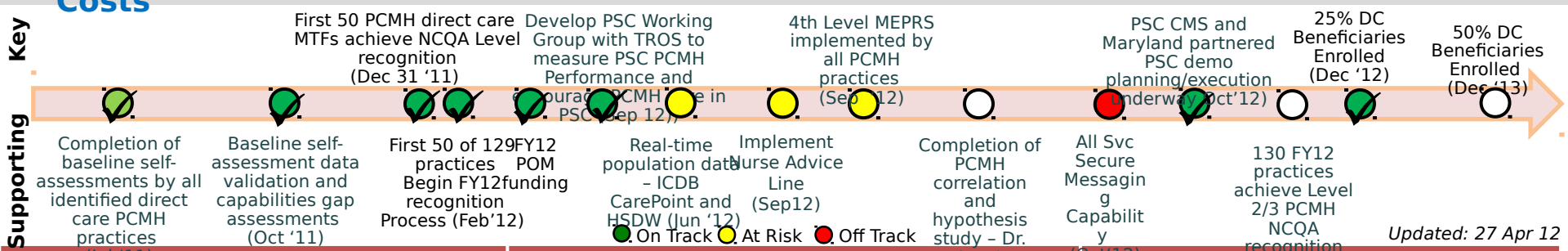
- *GAO Report "Applying Key Management Practices Should Help Achieve Efficiencies within the Military Health System", 12 Apr 12*

PCMH Governance



3. Implement Patient Centered Medical Home (PCMH) Model of Care to Increase Satisfaction, Improve Care and Control Healthcare Costs

POI: ASD(HA)
Executive Sponsor: DASD for C&PP
Leader: [Name redacted]
Working Group: PCMH Advisory Board
P&R Strategic Goal: #3



Updated: 27 Apr 12

Initiative Management

Source of Initiative

- In Dec 2009 MHS leadership decided to implement PMCH across all primary care platforms in the MHS in response to perceived gaps in patient satisfaction and rising healthcare costs.

Stakeholders

- Patients, line leadership, HA/TMA, OCMO, OSM, OTSG, BUMED, AFMS, MTF leadership and staff, Tri-Service PMCH Advisory Board and Working Group

Familiarity

- The PCMH initiative is managed through Tri-Service collaboration and governance. The Tri-Service PCMH Working Group (WG) reports to the Tri-Service PCMH Advisory Board (AB), which provides

Risks

- Accurate, timely, replicable data is key to PCMH success
- If sites don't have initiatives with achievable, outcome driven impacts, we will be unable assess pilot success
- TMA must ensure that any demonstrations or initiatives do not counter-effect PCMH operations or strategy.
- PPS poses significant risk to the PCMH model of care by driving counter-productive PCM behaviors
- MHS business intelligence tools must be
- Success is dependent on leadership involvement and support

Resource

Funding	FY12	FY13	FY14
POM	$74.1M	$92.3M	$105.6M
IM/IT	$9-13.5M	TBD	TBD

IM/IT Support

- High level PCMH IM/IT requirements approved by Tri-Service PCMH AB/coordinated with TMA/HA IM/IT 26-27 Apr 12
- Secure Messaging/Virtual Health is critical unfunded FY12

Initiative Overview

Current Fact Base

- Studies from civilian health and early pilots in the MHS indicate that the PCMH model of care has a positive impact on beneficiary satisfaction, population health, and costs (through reduction of specialty care and ER utilization but that improvements take longer to achieve than expected

Problem/Opportunity Statement

- Secure messaging is critical to demand management and to patient satisfaction; goal is to refund licenses for all team members, add-ons (smart phones, nurse triage, DM) and then add on specialty care users.
- Need better/actionable at clinic level cost and outcome measures
- Consistent implementation of 4th Letter MEPRS.
- Commander's Guide to Access Success must be revised to accommodate open access and to facilitate moving the MHS from a system of producing healthcare to one producing health.
- Better alignment between clinical/IM IT communities required as well as alignment between CMIO and CIOs – requirements must be driven by care
- TMA/Service initiatives affecting primary care must align with PCMH (UCC)
- No proposals affecting performance measures should be implemented without coordination with and concurrence of performance measure owners.

Expected Outcome

- Metrics to track performance in key areas of healthcare quality, continuity, satisfaction, readiness impacts and per capita costs
- Facilitate getting timely, relevant, accurate, replicable and actionable data quickly to the practice teams
- Identify and proliferate best practices across MHS.
- An overall positive impact measures tied to all four quadrants of the Quadruple Aim; development of better/actionable cost and outcome measures.
- Manage demand in non traditional ways, improve health of population and expand enrollment capacity leading to MTF optimization of resources.

Estimated Time to Impact

All practices should have transitioned to a PCMH model of care by the end of FY2016. Short: increased access, continuity, reduced ED use and higher satisfaction: Medium: Reduced PC/Spec usage. Long term: Increased

Current Performance

Performance Measure	Current	FY12 Goal	Diff from Goal	FY14 Goal	FY16 Goal
Enrollment in NCQA PCMH or Tri-Service Equivalent	2.3M	1.25M	84%	2.5M	3.34M

NCQA Level 2/3 PCMHs	# Enrollees	FY11 Practices	FY12 Practices	Total MHS Practices	%Practices Recognized Oct 12
MHS Overall	521K	47	130	460	39%

PCM Continuity	FY12 Qtr 1	FY12 Qtr 2	%Qtr Change	FY12 Goal	Diff from Goal
Overall MHS	53.0%	56.0%	5.7%	60%	-6.7%
PCMHs - MHS	57.8%	60.7%	5.2%	60%	1.2%
Diff PCMH vs. All	9.0%	8.5%			

3d Next Available	FY12 Qtr 1	FY12 Qtr 2	Quarterly Change	FY12 Goal	Qtr 2 Diff from Goal
3d Next *Acute* - MHS All	48.0	51.0	6.3%	62	-18%
3d Next *Acute* - PMCHs	49.0	54.0	10.2%	62	-13%
3d Next *Routine* - MHS All	69.0	72.0	4.3%	78	-8%
3d Next *Routine* - PCMHs	74.0	79.0	6.8%	78	1%

Avg "Days To"	FY12 Qtr 1	FY12 Qtr 2	Quarterly Change	MHS Std	PCMH Goal
Acute - MHS All	0.7	0.8	18.5%	1.0	0.5
Acute - PCMHs	0.6	0.6	-4.8%	1.0	0.5
Routine - MHS All	6.3	6.3	0.6%	7.0	4.0
Routine - PCMHs	7.0	6.5	-7.0%	7.0	4.0

ED Utilization (visits per 100 enrollees)	Overall	PCMHs	Diff.	FY12 Goal	PCMH Diff from Goal
MHS DC Overall	48	45	-6.7%	40	-13%

%Recapturable Care (Leakage)	Current	Previous	Improvement
MHS Overall	27	34	-20.6%
PCMHs	23	Not Avail	
Difference PCMH vs. MHS	-14.8%		

Satisfaction (Source: TROSS)	Overall Satisfaction	Primary Care Satisfation
MHS Overall	59	83
PCMHs	62	83
Difference PCMH vs. All	5.1%	0.0%

% PC Staff Satisfacation	% Satisfied Mar 12	% Satisfied Sep 11	Change Sep11-Mar12
Overall MHS	57.7%	59.0%	-2.2%

Tri-Service PCMH Advisory Board

- Highly collaborative/unified multi-disciplinary group
  - DOD/HA's example for DOD/P&R
  - Tri-Service leads (voting members) and TMA functional experts
  - Meets at least every 2 weeks
- Service Leads [Names redacted]
  - TMA:
  - Army:
  - Navy:
  - Air Force:
  - JTF CAPMED:
- Centralized Collaboration/Decentralized Execution
  - Each Service implements separately (Service Instructions)
  - More similar than different
  - One Voice

Stakeholders

- Our Patients
- GAO - Taxpayers
- Line Leadership
- DOD
  - Assistant Secretary of Defense/Health Affairs (ASD/HA)
    - Dr. Jonathon Woodson
  - Office of Management and Budget (POM)
  - Personnel and Readiness (Portfolio of Initiatives)
- Our Staff

ASD/HA

- FY2012 Priorities Memorandum, January 2012
  - #2 – "**Patient Centered Medical Home.** We have introduced the Patient Centered Medical Home for a number of good reasons. Its successful implementation has positively affected the health and health care delivery to our patients. It also supports our graduate medical education programs, and most importantly, continues to incentivize our patients to return to MTFs. Early evidence suggests we have demonstrated superior outcomes in preventive medicine and health screening in our Patient Centered Medical Home model. We will expand this model of care this year and set the pace for the civilian sector to follow. In so doing we intend to recapture some of the primary and specialty care that has migrated to the private sector and make our patients more satisfied with the clinical experience."
- MHS 2012 Focus Areas:
  - Optimize MTFs
  - Transform from a system of healthcare to health

ASD/HA

- FY2013 Priorities - Pending
  - Optimize MTFs
  - Reduce private sector care expenditures
    - Increased enrollment
    - Reduced utilization of specialty care
    - Recapture of private sector care (increased ROFR acceptance, etc.)

MHS Strategic Imperatives Scorecard

Readiness	Improve Individual and Family Medical Readiness		Medically Ready to Deploy		75%	75%	-	81%	82%	85%	Implement Policies, Procedures & Partnerships to Meet Individual Medical Readiness Goals
		TBD	Measure of Family Readiness (i.e., PHA for families)								
	Enhance Psychological Health & Resiliency	FHPC	PTSD Screening, Referral and Engagement (R/T)		48%/64%	42%/71%	-6%/+7%	50%/75 %	50%/75%	50%/75%	Integrate & Optimize Psychological Health Programs to Increase Resilience, Wellness & Readiness
		FHPC	Depression Screening, Referral & Engagement (R/T)		63%/69%	62%/74%	-1%/+5%	50%/75 %	50%/75%	50%/75%	Implement DoD/VA Joint Strategic Plan for Mental Health to Improve Coordination
Population Health	Engage Patients in Healthy Behaviors	CPSC	MHS Cigarette Use Rate (Active Duty 18-24)		26%	21%	-5%	19%	18%	16%	Support the National Prevention Strategy to Promote Healthy Behaviors & Total Fitness
		CPSC	Percent of Overweight/Obese Adults with Documented Weight Issue			17%/54%	-	30%/75 %	50%/90%	100%/100 %	
		CPSC	Percent of Overweight/Obese Adolescents/Children with Documented Weight Issue			11%/33%	-	30%/50 %	50%/75%	100%/100 %	
		CPSC	Exclusive Breastfeeding During Newborn Hospitalization		56%	62%	+6%	65%	70%	80%	
		CPSC	HEDIS Index: Preventive Cancer Screens & Well Child Visits (DC/PC)		7/6	8/6	+1/-	10/10	12/14	15/20	
Experience of Care	Deliver Evidence-Based Care	CPSC	HEDIS Index: Cardiovascular, Diabetic & Mental Health Care (DC/PC)		23/6	24/5	+1/-1	29/18	36/24	50/35	Support the National Partnership for Patients Effort to Improve Care, Transitions and Prevent Harm During Treatment
		CPSC	Hospital Readmission Rate		-	-	-	-	-	-	
		CPSC	Patient Safety - Wrong Site Surgery		-	-	-	-	-	-	
		CPSC	Antibiotic Received Within 1 Hour Prior to Surgical Incision		94%	95%	+1%	98%	98%	98%	
	Excel in Wounded, Ill and Injured Care	CPSC	Percentage of Medical Boards Completed Within 30 Days (DAR & IDES)		53%/67%	41%/53%	-12%/-14%	60%/60 %	TBD	TBD	Wounded Warrior Programs
		CPSC	Percent of Service Members Rating Medical Evaluation Board Experience as Favorable		51%	52%	+1%	65%	70%	75%	
	Optimize Access to Care	JHOC	Primary Care 3rd Available Appointment (Routine/Acute)		72%/50%	66%/52%	-6%/+2%	91/68%	92%/70%	94%/75%	Disability Evaluation System Redesign
		JHOC	Satisfaction with Getting Timely Care Rate		76%	77%	+1%	78%	80%	82%	
		JHOC	Potentially Recapturable Primary Care Workload for MTF Enrollment Sites		30%	34%	+4%	26%	24%	22%	Optimize Pharmacy Practices to Improve Quality and Reduce Cost
	Promote Patient-Centeredness	JHOC	Percent of Visits Where MTF Enrollees See Their PCM		51%	51%	-	60%	65%	70%	Implement Patient Centered Medical Home Model of Care to Increase Satisfaction, Improve Care and Reduce Per Capita Healthcare Costs
		JHOC	Satisfaction with Health Care		59%	59%	-	61%	62%	64%	Create Alternative Strategy for Purchasing Care to Improve Performance in Achieving the Quadruple Aim.
Per Capita Cost	Manage Health Care Costs	CFOIC	Annual Percent Increase in Per Capita Costs		5.8%	4.3%	-1.5%	3.1%	-	-	Implement Alternative Payment Mechanisms to Pay for Value
		CFOIC	Emergency Room Visits Per 100 Enrollees Per Year		47/100	50/100	+3	35/100	30/100	25/100	
Learning & Growth	Enable Better Decisions	CPSC	EHR Usability								Implement Modernized iEHR to Improve Outcomes and Enhance Interoperability
	Foster Innovation	CFOIC	Effectiveness in Going from Product to Practice (Translational Research)								Centers of Excellence
	Develop Our People	CPSC	Human Capital Readiness / Build Skills & Currency								Improve Governance to Achieve Better Quadruple Aim
		CPSC	Primary Care Staff Satisfaction								

Design Phase ○ Approved ◐ Funded ●

Performance Review

- PCMH is most accountable MHS measure
- PCMH and Behavioral Health (BH) POM Funding tied to Performance against set targets
  - FTEs Hired in primary care clinics
  - # Practices Transformed and # enrollees in PCMHs
  - Performance Measures against targets
- Key measures – Near Term
  - NCQA Recognition
  - Enrollees in MTF PCMHs
  - PCM Continuity
  - Access to Care
  - ED Utilization
  - Recapturable Primary Care (Leakage)
  - Patient Satisfaction
  - Staff Satisfaction

PCMH MTF Enrollment

- POM performance measure
- Limited by amount of NCQA recognition funding
- Tri-Service PCMH Criteria
  - Enrollees in NCQA Recognized PCMHs: 560K
  - Tri-Service PCMH practices: 1.9M

Service	Total Prime +Plus	#Enrollees in NCQA or Tri-Svc PCMHs	%MTF Enrollment
Army	1,455,375	900,000	62%
Navy	724,805	573,228	79%
Air Force	1,140,886	946,650	83%
JTF CapMed	89,682	33,096	37%
Total Direct Care	**3,410,748**	**2,452,974**	**72%**

Source: Services and TOC

Tri-Service PCMH Criteria

- NCQA Recognized Level 2 or 3
- Tri-Service PCMH Criteria (must meet all)

1. ***Enrollment Capacity Modeling***: Used Service methodology to review population size and needs (what, when)

2***. Demand Management*** (Scheduling Template/Templates): Simplified templates, analyzed demand and made changes to meet demand/access standards

3. ***Team-Based Practice***: Practice has transformed itself into team-based practices with identified roles for nurse, techs, etc. to accomplish population-based health management

4. ***Staffing Evaluations***: Compared existing staffing resources against the Service-specific standard, identifying if the practice has enough of all types of FTEs and taking corrective action to resolve the gaps

5. ***Standard Position Descriptions: Standard*** business rules for staff identifying actions they can take on their own without seeking permission, such as proactive care coordination, etc.

6. ***Co-location of practices***/team: is the practice organized in a way to increase communication and efficiency

7. Accomplishes daily ***huddles*** as well as periodic "Big Team" huddles to identify opportunities for process improvement

8. Team regularly reviews/posts the following ***metrics,*** identifying areas for improvement: access, satisfaction, Quality and HEDIS, Readiness, and ED Utilization

Examples

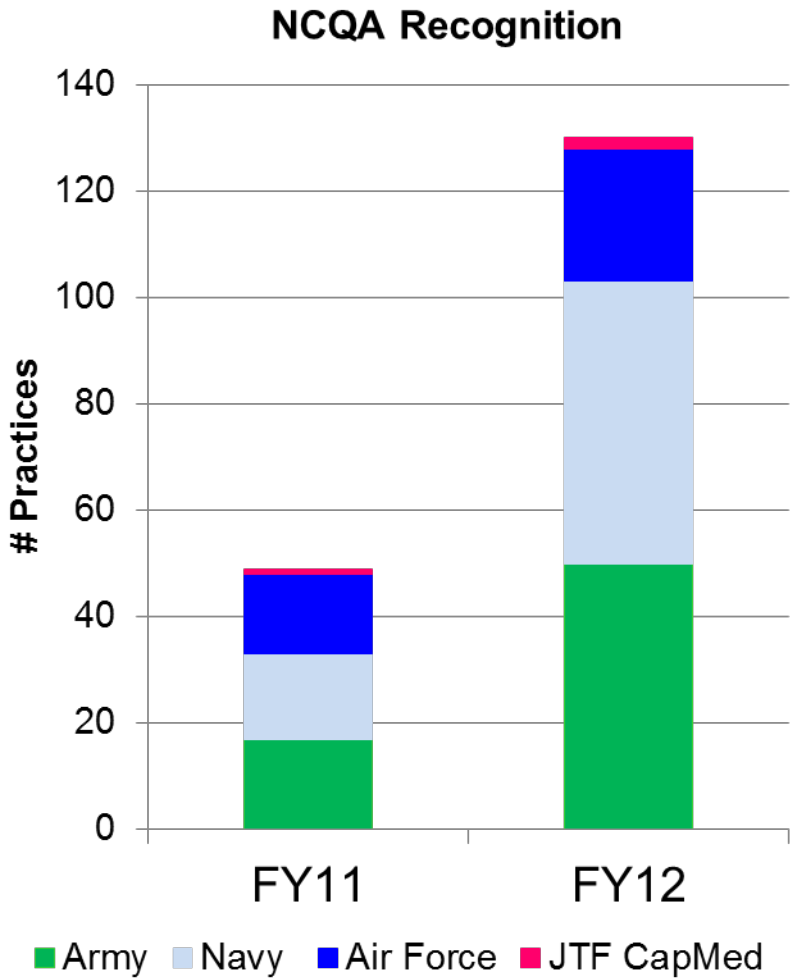

GOLD TEAM
GOLD TEAM - ER UTILIZATION
MISSION:
FORCE HEALTH PROTECTION
&
FAMILY CENTERED CARE!!!

Examples

Dr Jonathon Woodson
ASD/HA
Pentagon E-Ring
1 June 2012

NCQA PCMH Recognition

- FY11
  - 46 Level 3 PCMHs
  - 1 Level 2 PCMH
- FY12
  - Army: 50
  - Navy: 53
  - Air Force: 25
  - JTF CapMed: 2
- Support
  - 7 training events
  - MHS Guide to Recognition



NCQA Recognized PCMHs

MTF/Practice	STATE
Air Force	
ELMENDORF AFB	AK
LUKE AFB	AZ
DAVIS MONTHAN AFB	AZ
EDWARDS AFB	CA
TRAVIS AFB	CA
PATRICK AFB	FL
SCOTT AFB	MO
KEESLER AFB	MS
LAKENHEATH	OCONUS
WRIGHT-PATTERSON AFB	OH
SHAW AFB	SC
LAUGHLIN AFB	TX
HILL AFB	UT
LANGLEY AFB	VA
F.E. WARREN AFB	WY
Army	
Lyster Army Health Clinic, Family Practice Clinic	AL
Evans Army Community Hospital, Internal Medicine Clinic	CO
Evans Army Community Hospital, Warrior Clinic	CO
Evans Community Hospital, Premier Army Health Clinic	CO
Martin Army Community Hospital, Family Practice	GA
TMC 5, Martin Army Army Community Hospital	GA
Eisenhower Army Medical Center, Family Practice Clinic	GA
Tripler Army Medical Center, Internal Medicine Clinic	HI
Ireland Army Community Hospital, Military Readiness Clinic	KY
Dunham Army Health Clinic, Family Practice Clinic	MD
BG Crawford Sams Army Health Clinic, Primary Care Clinic	OCONUS
Andrew Rader Army Health Clinic, Family Medicine Clinic	VA
Madigan Army Medical Center, Family Practice Clinic	WA
Madigan Army Medical Center, Pediatrics Clinic	WA
Madigan Army Medical Center, McChord Family Medicine Clinic	WA
Madigan Army Medical Clinic, Okubo Family Medicine Clinic	WA
SFC Nathlan L. Winder Family Medicine Clinic	WA

+ Winn ACH Family Medicine

+ Hohenfels Primary Care

NCQA Recognized PCMHs

Navy	
Naval Medical Center San Diego	CA
TRICARE Outpatient Clinic Clairemont	CA
Naval Branch Health Clinic Washington Navy Yard	DC
Naval Hospital Pensacola, Family Practice	FL
Naval Hospital Pensacola, Internal Medicine	FL
Naval Hospital Pensacola, Pediatrics	FL
Naval Branch Health Clinic Naval Air Technical Training Center (NATTC) Pensacola	FL
Naval Branch Health Clinic Gulfport	MS
Naval Branch Health Clinic Meridian	MS
Naval Health Clinic Charleston	SC
Naval Branch Health Clinic Naval Support Activity (NSA) Mid-South	TN
Naval Health Clinic Quantico	VA
Naval Branch Health Clinic Little Creek	VA
Naval Health Clinic Quantico	VA
JTF CAPMED	
Walter Reed National Military Medical Center	MD

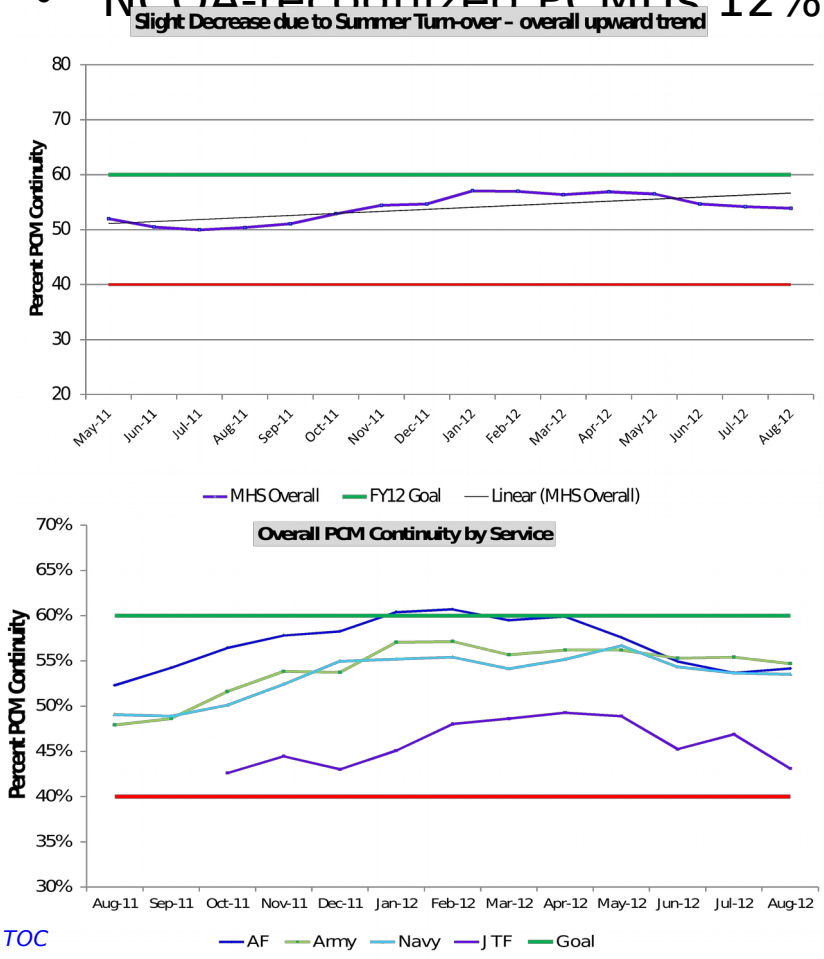
+ NH Rota
Family Medicine

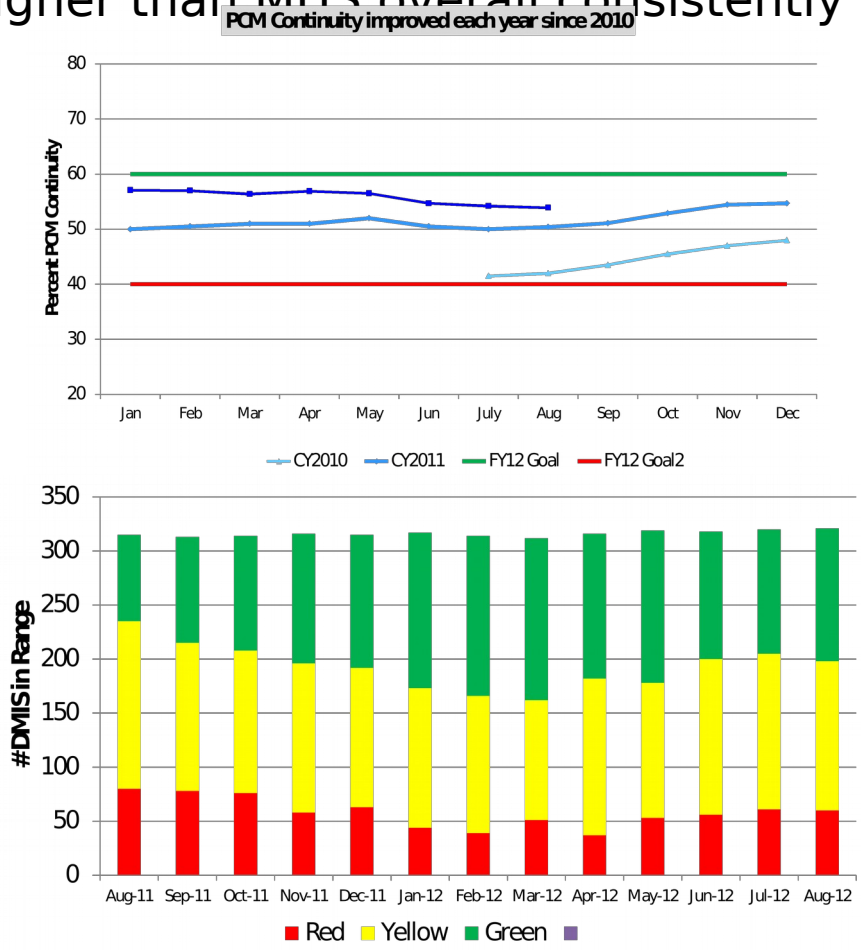
DHCAPE Beneficiary Choice Study

- Recent DHCAPE Study looked at what were single most important reasons for choosing direct vs. private sector care
- 49% response rate
- Top 2
  - #1 – PCM Continuity
  - #2 – Access to Care (especially Acute Care)
- PCMH addresses both issues

PCM Continuity

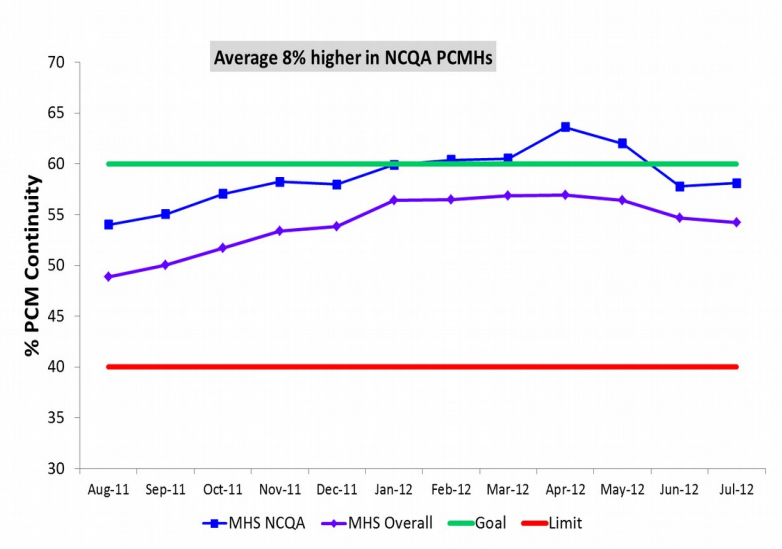
- Leading indicator of change - “Provider Accountability” metric
- Improving overall since Jul 10 – all three Services at similar level now
- NCQA-recognized PCMHs 12% higher than MHS overall consistently

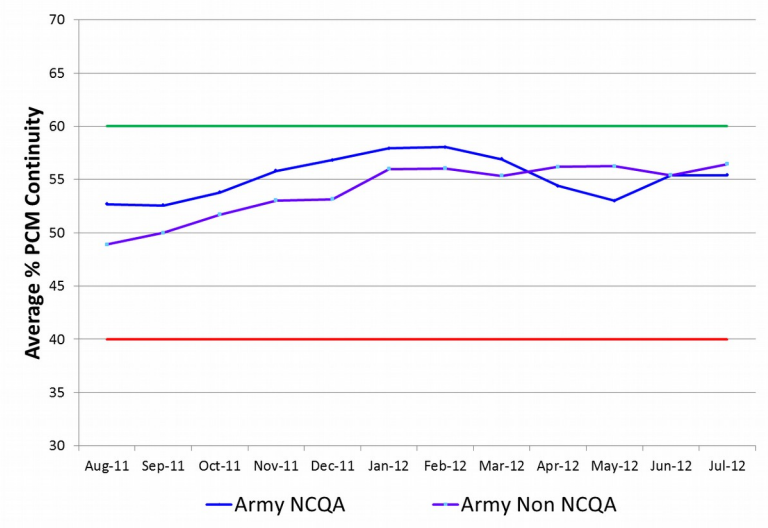


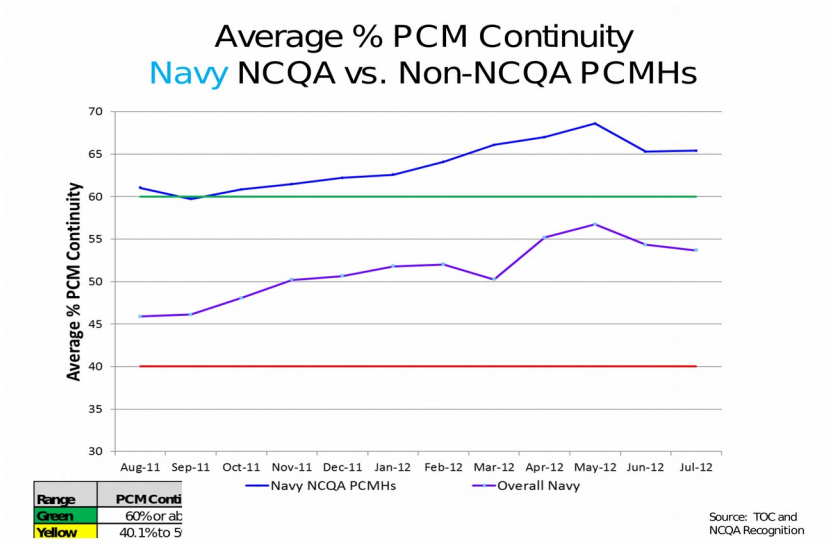


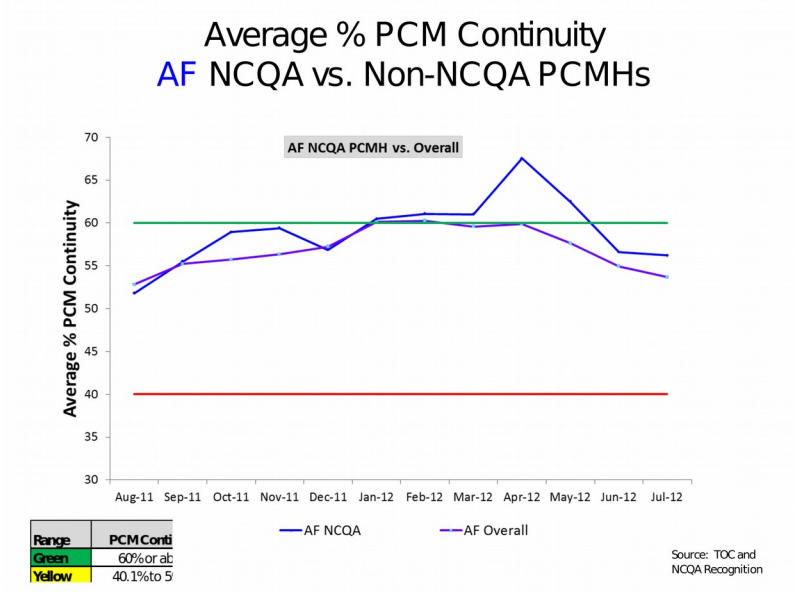
Source: TOC

PCM Continuity in PCMHs



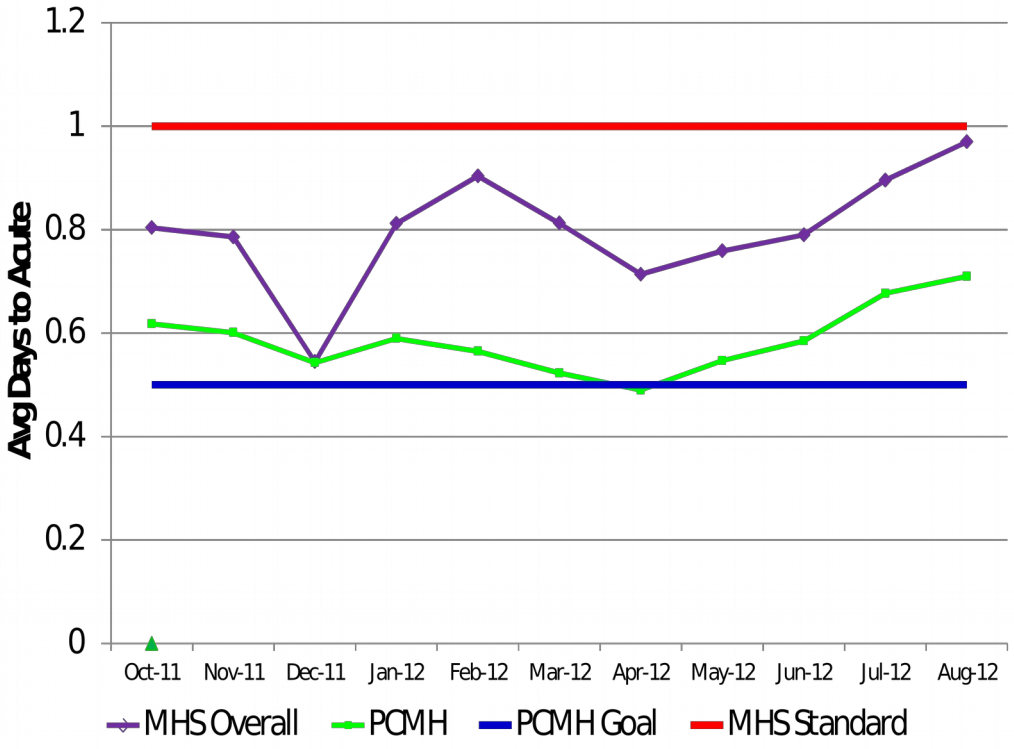


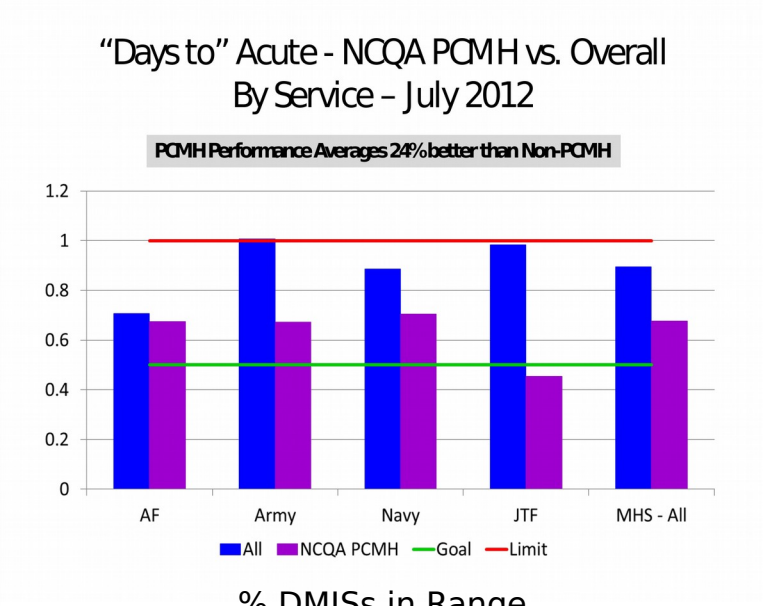


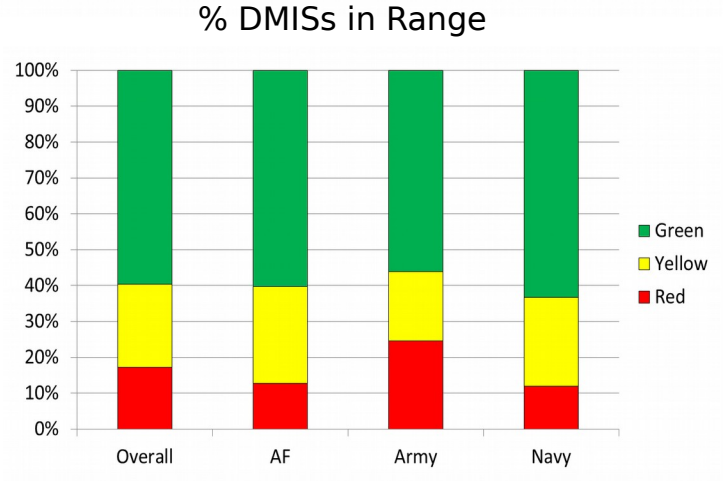


Access to Care – Days to Acute

- Access to Care key to fixing satisfaction and leakage
- "Days to" better in PCMHs

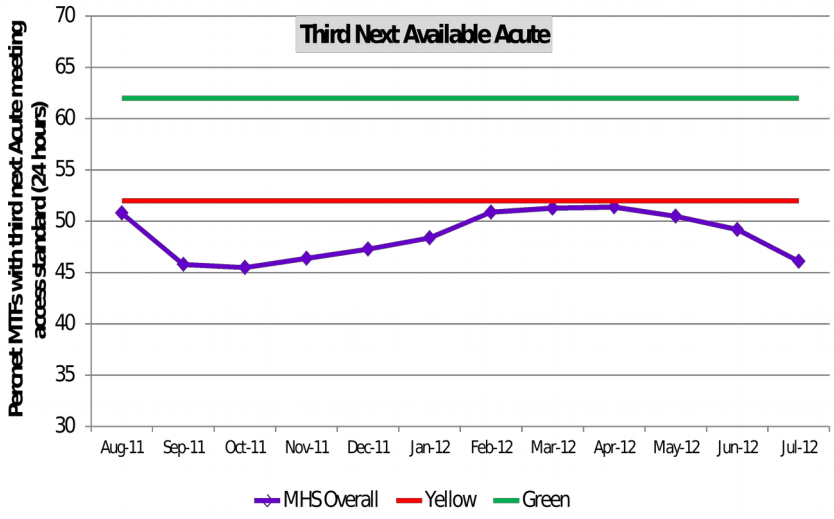


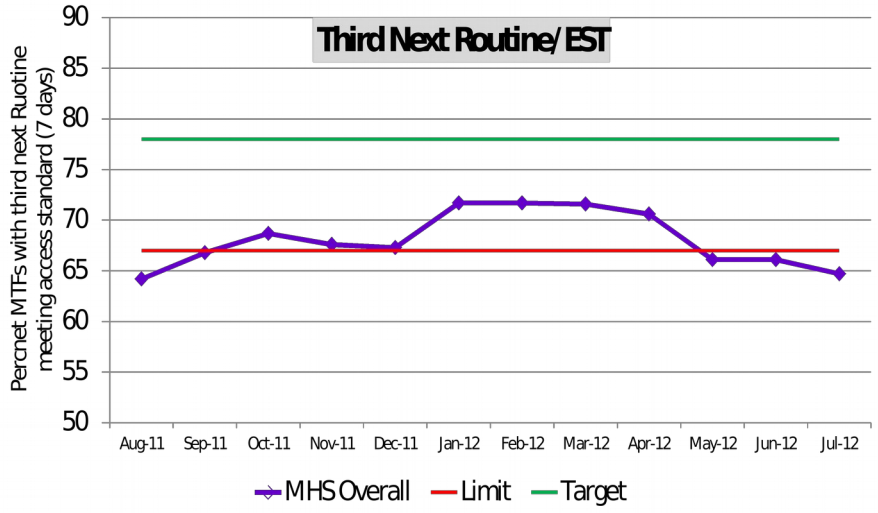


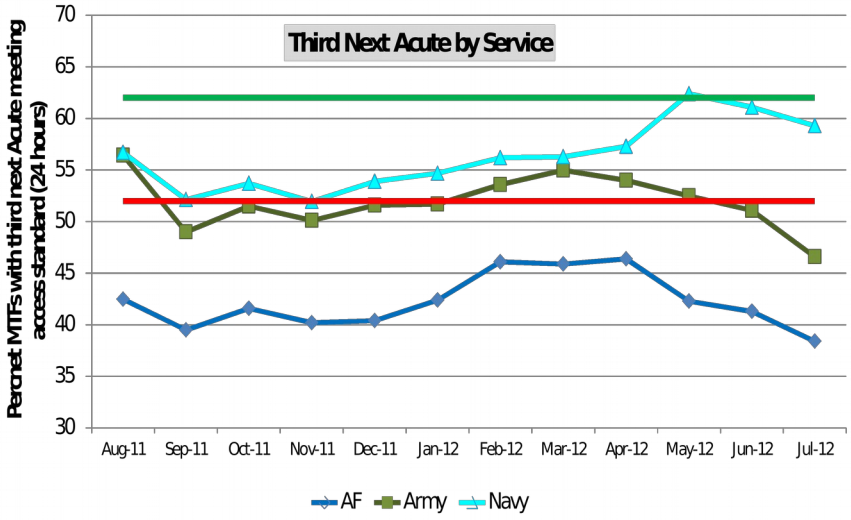


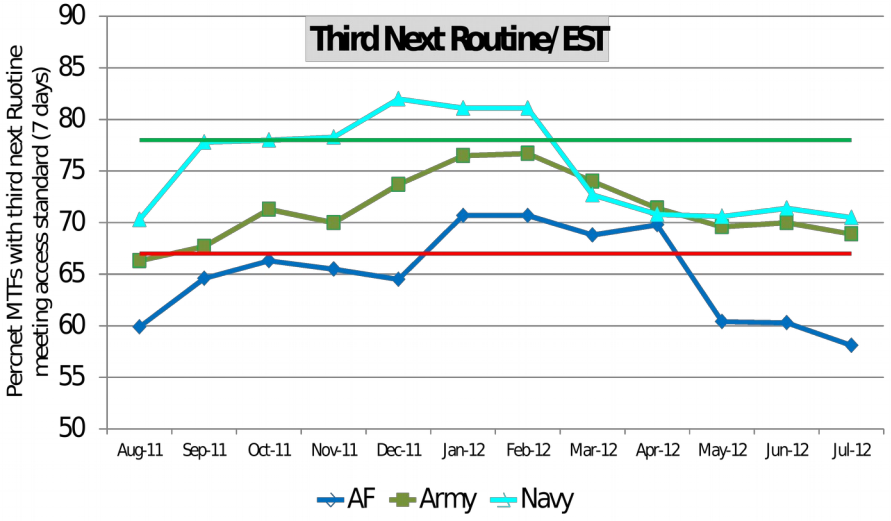
Source: TOC

ATC – Third Next Available



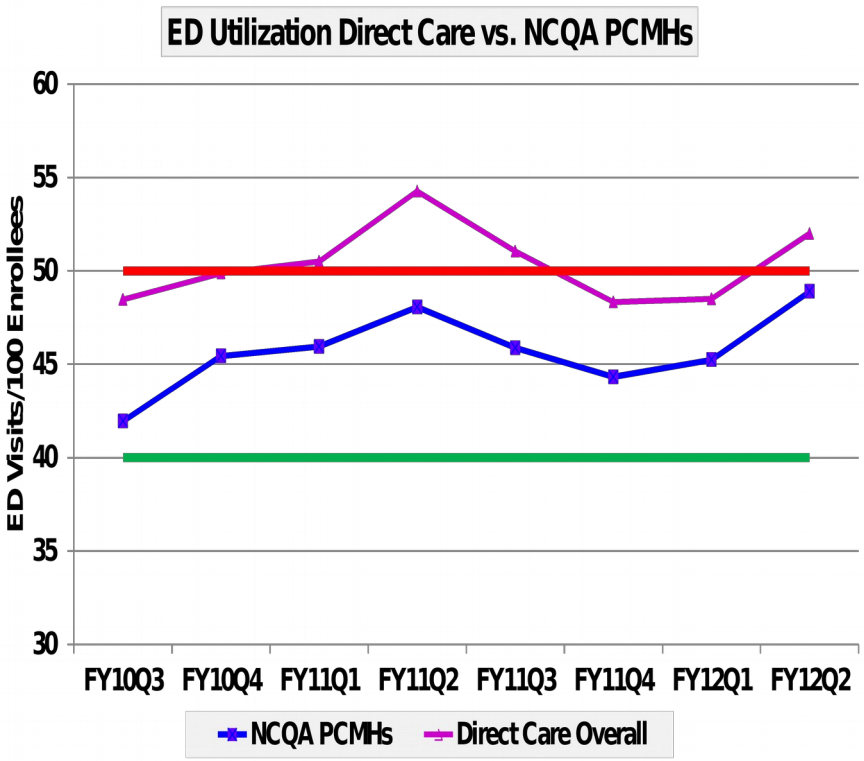






ED Utilization

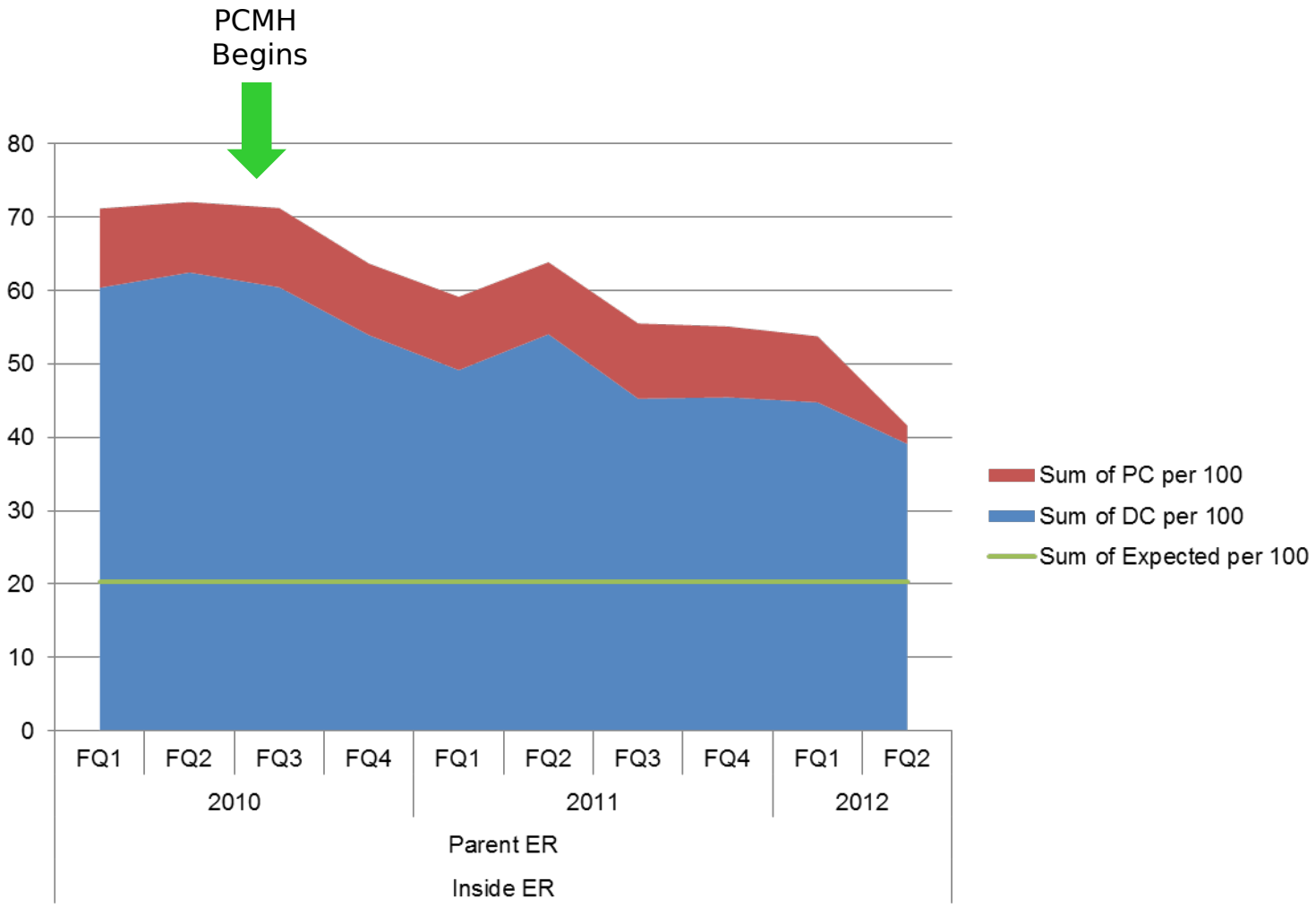
- ED Utilization will decrease as access/PCM continuity improves (and Secure Messaging and NAL implemented)
- MHS PCMHs average in the yellow range
- PCMHs have lower ED utilization than direct care overall
  - Lowest: AF 41.9/Navy 42.3
- Large MTFs with emergency rooms (ERs) have *significantly higher* utilization than PCMHs in small MTFs with no ERs
  - Madigan is exception at 2 year average 38.5/visits/100 enrollees (green)



Source: HPA&E

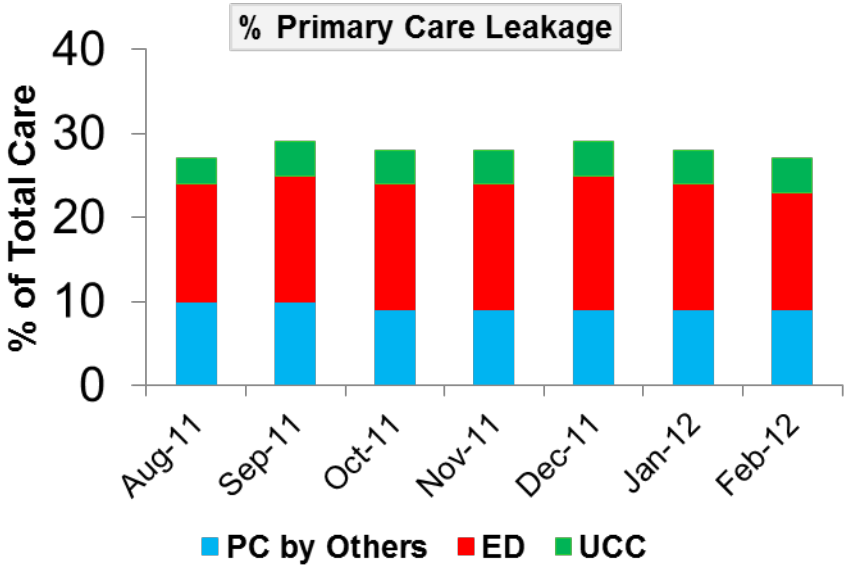
MTF	Svc	Total FY10Q3	Total FY10Q4	Total FY11Q1	Total FY11Q2	Total FY11Q3	Total FY11Q4	Total FY12Q1	Total FY12Q2
EDWARDS AFB	AF	21.26	23.33	20.42	23.98	23.62	26.61	25.64	26.17
SHAW AFB	AF	31.96	33.22	30.76	32	30.21	33.44	30.53	28.39
NH Charleston	N	31.14	29.51	35.61	30.52	28.64	27.89	26.82	29.22
PATRICK AFB	AF	26.16	24.03	25.28	24.72	26.03	28.63	26.35	29.27
HILL AFB	AF	31.10	34.26	30.01	34.65	33.43	34.86	31.90	31.81
LAUGHLIN AFB	AF	32.01	32.1	35.66	38.77	27.56	34.17	34.05	33
DAVIS MONTHAN AFB	AF	34.52	33.58	33.47	34.77	33.99	30.66	29.29	33.05
Lyster Army Health Clinic, Family Practice Clinic	A	36.98	35.54	34.58	35.17	34.66	31.93	32.22	33.14
Andrew Rader Army Health Clinic, Family Medicine Clinic	A	35.43	34.38	33.9	35.83	34.07	35.25	35.25	35.35
SCOTT AFB	AF	29.91	32.49	32.59	37.26	36.37	32.88	32.71	39.21
Quantico	N	37.16	38.19	37.24	38.18	37.34	39.32	39.56	40.02
Madigan Army Medical Center, Family Practice Clinic	A	31.81	36.61	38.3	43.79	42.06	38.07	36.76	40.46
LUKE AFB	AF	40.86	40	39.51	42.2	37.57	36.6	35.99	41.11
Tripler	A	40.51	40.67	42.71	44.58	42.17	41.86	45.33	44.86
F.E. WARREN AFB	AF	38.73	39.69	39.94	53.18	41.26	42.14	44.36	45.01
San Diego	N	40.31	41.97	41.14	45.32	41.74	40.29	41.85	47.34
Pensacola	N	36.4	51.41	49.31	51.71	46.8	46.6	45.86	47.44
TRAVIS AFB	AF	49.71	49.27	50.01	56.84	56.78	53.32	53.88	58.04
Martin, Ft Benning	A	52.78	56.52	64.71	67.62	64.18	63.9	63.50	59.94
Portsmouth	N	58.29	57.3	62.18	68.81	66.63	57.51	56.82	63.56
WRIGHT-PATTERSON AFB	AF	61.56	66.93	63.02	63.18	60.91	60.88	60.11	63.81
Evans Ft Carson	A	73.66	72.74	72.93	70.27	67.48	66.82	64.53	67.07
Ireland	A	60.66	72.38	64.97	56.45	55.45	61.4	60.60	70.43
Elmendorf	AF	54.82	61.95	65.58	71.8	69.97	67.38	66.54	74.43
KEESLER AFB	AF	68.16	71.52	80.48	84.39	77.28	76.91	68.58	75.04
Eisenhower	A	52.66	56.34	56.57	63.1	62.11	67.46	68.32	75.25
LANGLEY AFB	AF	not avail	92.71	93.82	92.87	86.68	59.68	81.35	88.74

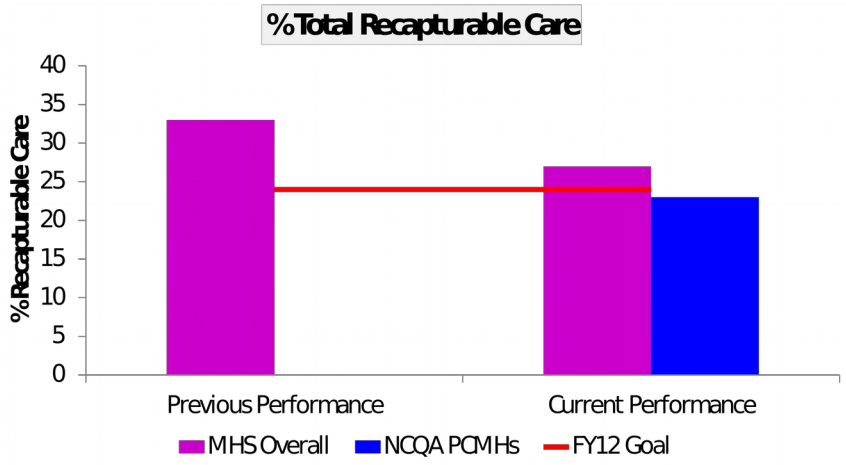
ED Utilization – Pensacola Example



Potentially Recapturable Primary Care Workload for MTF Enrollment Sites

- Primary Care leakage has improved for three consecutive months
  - ED utilization declined 12.5% as a percent of all care
  - PC by others and UCC utilization remained steady
- Overall, leakage decreased from 33% in Dec 11 to 27%
- NCQA-recognized PCMH leakage averaged 23%
  - Achieved FY12 target of 24%
  - Retrospective data analysis underway

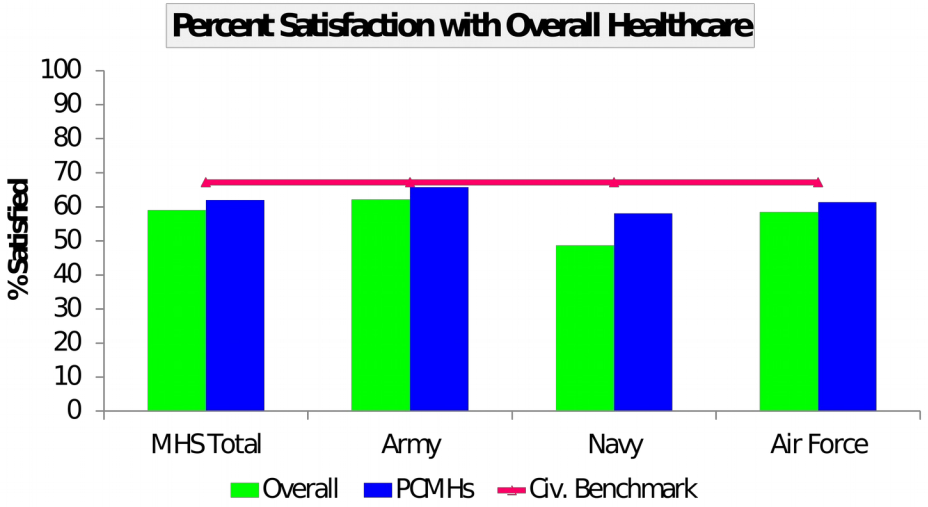


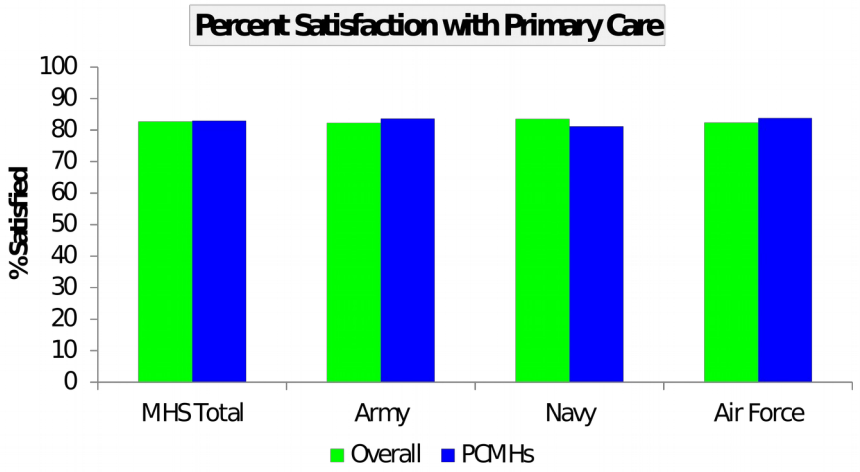


Source: HPA&E

Patient Satisfaction

- Overall Patient Satisfaction with healthcare is lower than civilian benchmark
- Satisfaction is higher in NCQA-recognized PCMHs
  - Army has highest satisfaction
  - Navy has greatest difference between NCQA recognized PCMHs and non-recognized
- Tri-Service PCMH Advisory Board working with DHCAPE to refine metric down to satisfaction with Primary Care
  - Best measure is 3QC
  - Average is 83% for both cohorts

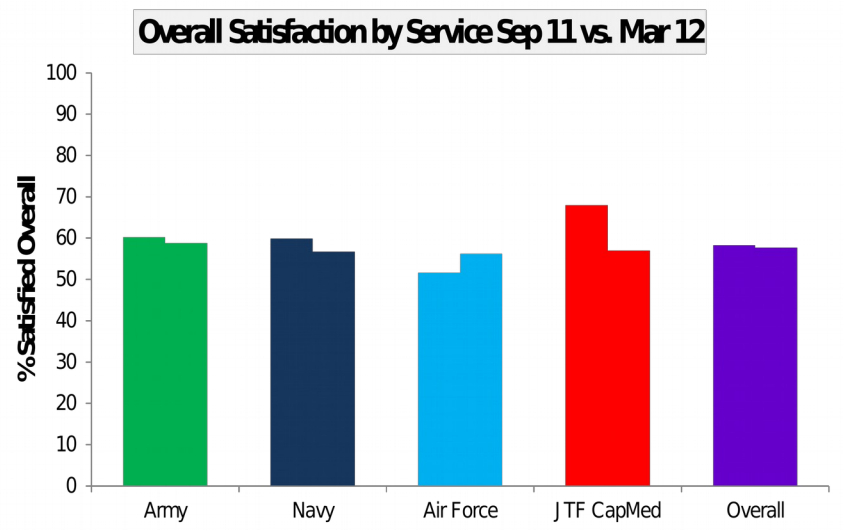


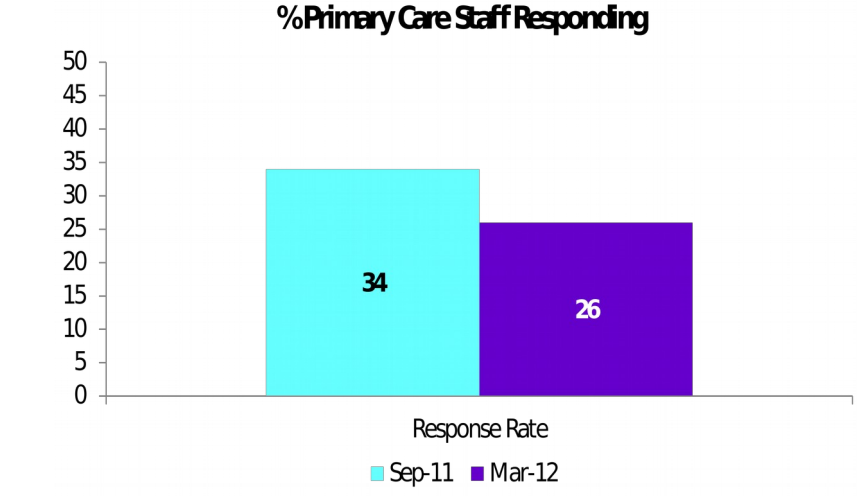


Source: DHCAPE/TROSS

Primary Care Staff Satisfaction

- Dec 11 MHS R&A approved twice yearly survey
- Just completed first FY12 survey (Mar 12)
  - Lower response rate than in Sep 11 (34 vs 26%)
  - Satisfaction 2% lower overall at 58% (vs. 59% in Sep)
    - Service satisfaction rates similar
- Open-ended comments
- New Survey being developed
  - FY13 fielding



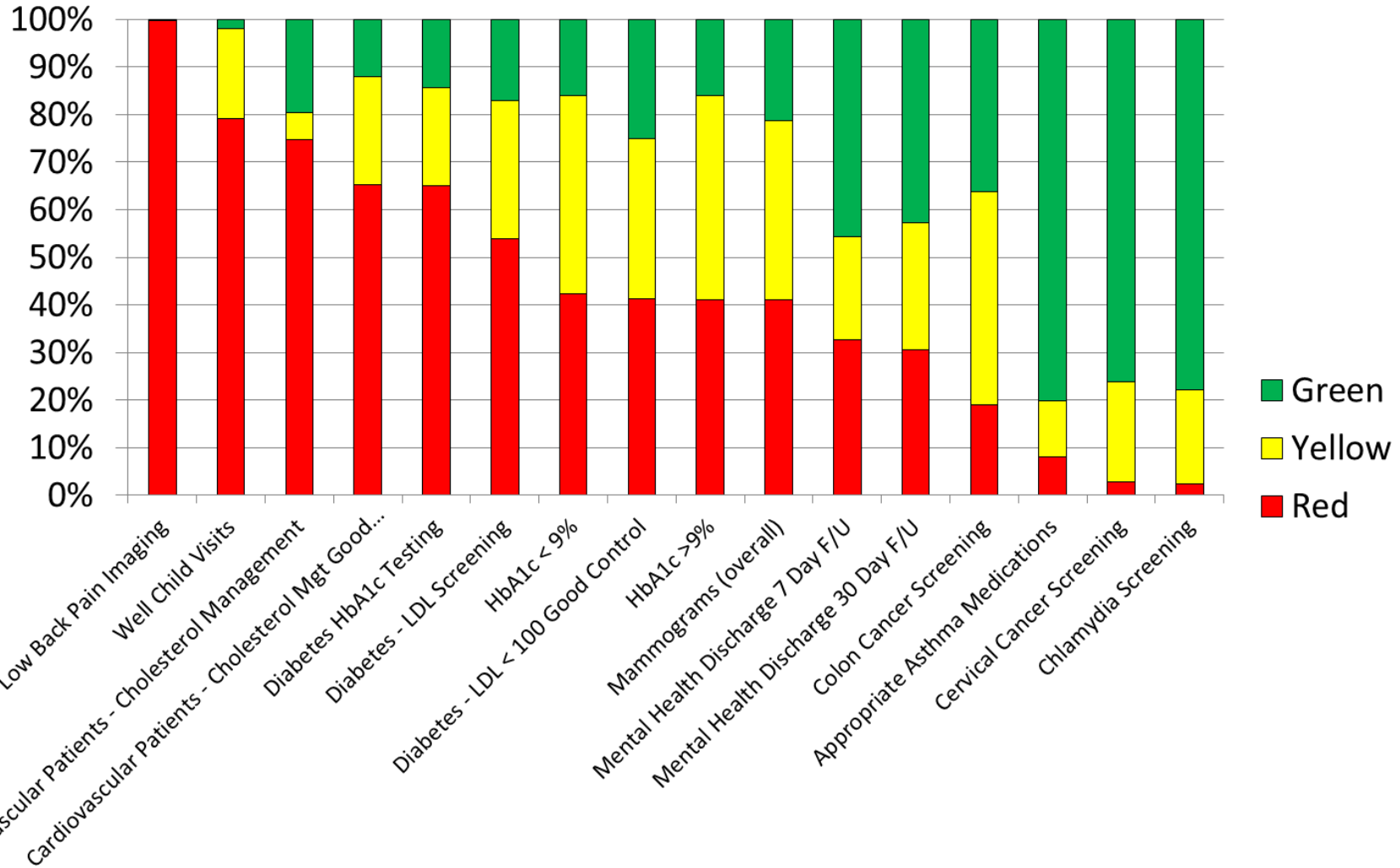


Source: DHCAPE/Zogby

Primary Care Staff Satisfaction

- Satisfaction correlated to
  - More and appropriate training/defined staff roles
  - Appropriate skills utilization
  - Ability to handle walk-in appointments/meet patients' needs
  - Ease of providing follow-up care
  - High quality team collaboration
  - Strong leadership support
- Dissatisfaction correlated to
  - Team members having to perform others' tasks
  - Personnel/staff shortages
- MHS Strategy Review and Analysis Committee approved semi-annual survey – stand-down FY12

HEDIS - % MTFs in Range



CONUS NAL Features

- Funded by proposed PSC recapture
- Toll-free 24/7 telephone access to RNs, via 1-800-TRICARE and a common MHS-wide approach
  - Available for all TRICARE beneficiaries
- Use RNs to provide beneficiaries clinical advice based on nationally recognized protocols and guidelines
- Provide a ancillary appointing service that will allow beneficiaries enrolled to a MTF to:
  - Cancel/reschedule pre-existing appointments
  - Post-triage appointment booking to PCMH
  - Requires practice business rules
- Disposition of all calls in T-Cons

Sample Shift in Care (Europe)

Caller Intent	Count	% of Total	Nurse Recommendation	Count	% Of Total Calls	Patient Action	Count	% of Total Actions
Seek Care ER	8857	34.24%	Emergent	1904	7.36%	Emergent Care	2835	10.96%
Seek Urgent Care	1172	4.53%	Urgent Care	659	10.28 %	Urgent Care	367	1.42%
Make Clinic Appt	8322	32.17%	Make Clinic Appt	2733	57	Make Clinic Appt	8057	31.15%
Speak to Provider	4495	17.38%	Speak to Provider	9086	35.13 %	k to Pro	2575	9.95%
Self Care	2428	9.39%	Access Self Care	9485	36.66 %	Self Care	12033	46.52%
Other/Not asked	593	2.29%						
	25867	100.00 %		25867	100%		25867	100%

NAL Goals and Status

- Support MTF PCMH operations
- Increase access to (appropriate level of) care
- Increase patient satisfaction
- Lower per capita costs
  - Major PMPM driver is ER utilization
  - Tri-service MHS IIP team drafted RFP
  - NAL Policy approved by DOD(HA) – no redundancy
  - SSEB reps from each Service and MTF with current NAL
  - Rollout schedule:
  - Alaska & Hawaii – Jun/July 2012
  - CONUS – Jul/Aug 2012
  - Tri-Service Monitoring – performance measures/feedback

Opportunities

- PCMH transformation is a process
  - We need continued leadership support and emphasis (sustainment)
- Credit for workload
  - Secure messaging and Care Coordination
- Beneficiary Communication and Outreach (Campaigns)
- Focus on performance
  - Best Practice proliferation
  - MTF Cost and Utilization Guidance (PMPM, etc.)
  - Focus on High Utilizers/Chronically Ill
- Patient and Provider (fully empaneled) advisory councils
- Expanding patient-centered spectrum of care through specialty care optimization and standardization

Data Quality

- We don’t know how you are doing unless we have confidence in the data
- We need your help
- You are a critical part of our PCMH team
- Feedback for us?

Questions?

http://www.tricare.mil/tma/ocmo/PatientCenteredMedicalHome.aspx

www.facebook.com/MHSPatientCenteredMedicalHome